Doctors and global health security

Doctors and Global Health Security: What Role for Ethics and Regulation?

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Introduction

In an increasingly interconnected world, the potential for the rapid cross-border spread of infectious diseases is growing with often wide-ranging social, political and economic consequences for nation-states, as well as tragic consequences for the health and wellbeing of their citizens. In the closing decades of the twentieth century, it was recognized that action was needed at global level to reduce the spread of the HIV/AIDS pandemic, which was increasingly seen as posing a threat to state security and stability.[1] In the new millennium, successive outbreaks of infectious disease and their potential link to bioterrorism in a post 9/11 world, led to calls on the part of political leaders in the Global North for concerted global action on health threats as part of a broader biosecurity agenda.[2] Against this background, the emerging global health security agenda gained traction and was given impetus by the adoption of revised International Health Regulations (IHR), which came into force in 2007.[3] Representing a watershed moment in global health,[4] the IHR established a legally-binding framework promoting an all-threats approach to managing public health emergencies of international concern

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[1] Colin McInnes and Simon Rushton, 'HIV, AIDS and Security: Where Are We Now? (2010) 86(1) International Affairs 225.

[2] David P Fidler and Lawrence O Gostin, *Biosecurity in the Global Age: Biological Weapons, Public Health, and the Rule of Law* (Stanford University Press 2007); Stefan Elbe, Anne Roemer-Mahler and Christopher Long, 'Medical Countermeasures for National Security: A New Government Role in the Pharmaceuticalization of Society' (2015) 131 Social Science & Medicine 263; Christian Enemark, *Biosecurity Dilemmas*: *Dreaded Diseases, Ethical Responses and the Health of Nations* (Routledge 2017).

[3] The International Health Regulations (IHR) (3rd edn, 2005) came into force on 15 June 2007, and are currently binding on 196 countries, see <www.who.int/topics/international_health_regulations/en/> accessed 27 April 2019.

[4] Fidler and Gostin (n 2).

(PHEIC), underpinned respect for by human rights principles.[5] For the first time, the World Health Organization (WHO) was given powers to make a PHEIC declaration, as well as to undertake independent surveillance of, and respond to, emerging cross-border threats to health.[6]

The WHO's promotion of a global health security agenda,[7] underpinned by its new IHR powers, represented a shift away from an approach to managing health threats which had long been driven by a public health/international development perspective which focused on human rights and welfare, as well as capacity-building in local health systems.[8] It is a shift that has also been mirrored at the regional level, with the EU having also established a regulatory framework for managing 'serious cross-border threats to health'.[9] Like the IHR, the EU regulatory approach promotes an all-threats approach and makes explicit the link between health and security. This shift has led to the development of a common approach to preparedness, planning and crisis response in relation to a range of health threats. In addition, the EU now has powers to declare a public health emergency, separately from the WHO; to conduct independent scientific risk assessments; and to stockpile vaccines and diagnostics in the event of (pandemic) infectious disease outbreaks.[10] When such outbreaks occur, doctors are often on the frontline in terms of treating infected individuals, as well as engaging in risk assessment and management at the population level. National and international ethical and regulatory obligations have an influential role in the performance of such work.

[5] Public health emergencies of international concern (PHEIC) are defined as 'an extraordinary public health event which is considered to constitute a public health risk to other States through the international spread of disease and to potentially require a coordinated international response', see IHR, Art 1.
[6] IHR, Arts 5, 9 12, 13.
[7] World Health Organization, *The World Health Report 2007 – A Safer Future: Global Public Health Security in the 21st Century* (WHO 2007).
[8] William Aldis, 'Health Security as a Public Health Concept: A Critical Analysis' (2008) 23(1) Health Policy and Planning 369; Michael Selgelid and Christian Enemark, 'Infectious Diseases, Security and Ethics: The Case of HIV/AIDS' (2008) 22 Bioethics 457.
[9] Decision No 1082/2013/EU of the European Parliament and of the Council of 22 October 2013 on serious cross-border threats to health and repealing Decision No 2119/98/EC, OJ L 293, 5.11.2013, p. 1.
[10] Report from the Commission to the European Parliament and the Council. Report on the implementation of Decision No 1082/2013/EU of the European Parliament and of the Council of 22 October 2013 on serious cross-border threats to health and repealing Decision No 2119/98/EC, Brussels, COM (2015) 617 final, 7.12.2015.

However, the growing prominence of a securitization approach to managing such health threats raises a number of ethical and regulatory concerns about how this will impact upon doctors' adherence to such obligations, particularly where they are confronted with competing political, military or security imperatives. For example, how do doctors engage in ethically acceptable medical practice in securitized environments? What national and international regulatory obligations apply in such circumstances? How will doctors balance the demands of ethically acceptable medical practice with security imperatives? These questions are examined in more detail in this chapter, drawing on the concept of medicalization in the global health security literature.

Drawing largely on a Foucauldian perspective, the term has been used in this literature to describe the way in which those with medical expertise – such as practising doctors and policy-makers with such expertise – have sought to extend their influence and power through engagement with securitization discourse and practices in managing global health threats,[11] particularly as they relate to infectious diseases.[12] I argue that taking account of the key roles played by ethics and regulation in medical practice in securitized environments will provide a fuller and more nuanced account of the process of medicalization and its impact on global health security. In order to explore this argument, an overview is first provided of key aspects of securitization theory, particularly as it applies in the area of health. The concept of medicalization is then examined, with select examples provided as to how ethics and regulation impact the work of doctors in addressing global health threats, such as pandemic infectious diseases (hereinafter referred to as health threats). What this means for how we should now understand the relationship between medicalization and global health security is explored in the final section of the chapter.

[11] Within critical security studies scholarship, see Stefan Elbe, *Security and Global Health: Toward the Medicalisation of Insecurity* (Polity Press 2010). For an overview of the origins and application of the term 'medicalization' within the sociological literature, see Deborah Lupton, 'Foucault and the Medicalisation Critique' in Alan Peterson and Robin Bunton (eds), *Foucault, Health and Medicine* (Routledge 1997) 94-110.

[12] For present purposes, the term 'infectious diseases' is used to describe the 'spread from one person to another and are caused by pathogenic micro-organisms, such as bacteria, viruses, parasites or fungi, with zoonotic infectious diseases being those which can be spread between animals and humans', see World Health Organization, Infectious Diseases <https://www.who.int/topics/infectious_diseases/en/> accessed 15 April 2019.

Security and securitization

Questions of security, and the circumstances in which securitization takes place, have long been the subject of examination in the international relations literature. Within the realist tradition, the focus has been for the most part on the role of the state as the referent object, which has involved examination of questions of state sovereignty in times of conflict or war, including whether the principle of non-interference in such sovereignty is justified or not. From this perspective, a political problem for a state comes to be framed as a security issue when there is a threat that poses a clear and present danger to the state's existence. A sense of urgency is created when such a threat is framed as a security issue, requiring immediate and targeted action on the part of the state, as well as global political leaders.

Two prominent groups of critical security studies scholars – colloquially known as the Copenhagen and Welsh Schools – have offered sustained critiques of the realist tradition.[13] For the Copenhagen School, the conceptual shift towards securitization is seen as performative, involving speech-acts by those in (political) authority which serve to reframe political problems, that are perceived as existential threats or dangers to the state, as a security issue. Empirical claims may be made in support of securitization, emphasizing the nature and scale of the threat. Once this reframing has occurred with the consent of relevant constituencies, the taking of exceptional actions is justified above and beyond normal politics.[14] The strength of this particular approach is said to lie in its normative appeal, focusing as it does on how securitization advances particular agendas by suspending standard operating procedures in the political sphere. Nevertheless, it has been subject to criticism on the grounds that it promotes a universalising logic in accounting for the shift towards securitization, which offers little in the way of elaboration of process and progress,[15] and is largely Eurocentric in focus.[16]

[13] Stephen M. Walt, 'Renaissance of Security Studies' (1991) 35(2) International Studies Quarterly 211.
[14] Barry Buzan, Ole Weaver and Jaap de Wilde, *Security: A New Framework for Analysis* (Lynne Reiner 1998) 24.
[15] Matt McDonald, 'Securitization and the Construction of Security' (2008) 14(4) European Journal of International Relations 563; Christopher Browning and Matt McDonald, 'The Future of Critical Security Studies: Ethics and the Politics of Security' (2011) 19(2) European Journal of International Relations 235.
[16] Catherine Lo Yuk-ping and Nicholas Thomas, 'How Is Health A Security Issue? Politics, Responses And Issues' (2010) 25(6) Health Policy and Planning 447.

In contrast, the Welsh School has examined how knowledge and power influences the framing, structure and response to security threats, as well as the shift towards securitizing such threats. Within this school of thought, human emancipation is placed at the forefront of analysis and threats are viewed as social constructed, with critique focused on key questions such as: whose security is at stake? What interests are served by a securitization framing and why?[17] Emphasis is also placed on the need to be reflexive in identifying how and why securitization occurs. This includes taking account of when desecuritization does or should take place, and the circumstances in which security threats should be managed in the context of normal politics and processes.[18]

While states remain prominent in the Copenhagen School's critique, the Welsh School's focus on human emancipation aligns to a much greater extent with broader questions concerning human welfare and protection. These are matters of central concern in the human security literature, which recognises that state sovereignty is necessarily interdependent with fulfilling the needs, rights and entitlements to freedom and protection from harm for individuals and communities.[19] This particular critique of the realist tradition has also proved to be influential in claims made by critical security scholars for the referent object to be cast more widely beyond the state, to include threats to the environment and health.[20] It is against this background of broader academic debates involving security and securitization that I now turn in the next section to explore how this has influenced global health security research.

Securitizing health threats

For the most part, threats to health had traditionally been viewed as a question of 'low politics' in comparison to the 'high politics' of international security involving threats of war and military force,

[17] Ken Booth, 'Beyond Critical Security Studies' in Ken Booth (ed), *Critical Security Studies and World Politics* (Lynn Rienner 2005) 259-78; Richard Wyn-Jones, 'On Emancipation: Necessity, Capacity and Concrete Utopias' in Ken Booth (ed), *Critical Security Studies and World Politics* (Lynn Rienner 2005) 215-35.
[18] Lene Hansen, 'Reconstructing Desecuritisation: The Normative-Political in the Copenhagen School and Directions for How to Apply It' (2012) 38(6) Review of International Studies 525.
[19] Report of the Commission on Human Security, *Human Security Now: Protecting and Empowering people* (United Nations 2003)
[20] Rita Floyd, 'Can Securitization Theory be Used in Normative Analysis? Towards a Just Securitization Theory' (2011) 42(4-5) Security Dialogue 427; S Neil MacFarland and Yuen Foong Khong, *Human Security and the UN: A Critical History* (Indiana University Press 2006); Mary Kaldor *Human Security* (Polity Press 2007).

with little thought given to the relationship between the two.[21] In the latter half of the twentieth century, such a view was reinforced by the fact that the global burden of infectious disease appeared to be diminishing. With the eradication of smallpox in the 1970s, there was a growing consensus that the problems created by infectious disease were now under control, at least in the Global North.[22] This consensus was subsequently challenged with the emergence of HIV/AIDS as a global pandemic in the closing decades of the twentieth century. This was accompanied by a recognition that action was needed at the global level to reduce its impact, given the ongoing threat it posed to state security and stability.[23] By the turn of the millennium, a range of what were now described as health threats had become part of a broader biosecurity agenda, underpinned by concerns about the potential impact of bioterrorism in a post-9/11 world.[24]

Against this background, the global health security agenda emerged, supported by the adoption of an all-threats approach to managing global health emergencies in the IHR.[25] Since the turn of the millennium, however, successive outbreaks of (pandemic) infectious disease have shown that this agenda is now largely being shaped by the political prerogatives and security agendas of countries in the Global North, which for the most part focus on protection of their own populations and borders.[26] Indeed, the Global North's focus in this regard remains at odds with the predominant focus on managing health threats from a public health/international development perspective in much of the Global South. Such perspective instead prioritizes respect for human rights and human security in and across borders, and recognizes the importance of building institutional and systems capacity to address such threats.[27] Against this background, one of the key policy dilemmas facing international organizations, such as the

[21] Fidler and Gostin (n 2); cf Jeremy Youde, 'High Politics, Low Politics And Global Health' (2016) 1(2) Journal of Global Security Studies 157.
[22] Allen Brandt, *No Magic Bullet: A Social History of Venereal Disease in the United States Since 1880* (Oxford University Press 1987).
[23] McInnes and Rushton (n 1).
[24] Elbe et al (n 2).
[25] Fidler and Gostin (n 2); World Health Organization 2007 (n 7).
[26] Elbe (n 11); Colin McInnes, 'Health' in Paul D Williams (ed), *Security Studies: An Introduction* (2nd edn Routledge 2013) 324-36.
[27] William Aldis, 'Health Security as a Public Health Concept: A Critical Analysis' (2008) 23(6) Health Policy and Planning 369; Michelle L Gagnon and Ronald Labonté, 'Understanding How and Why Health is Integrated into Foreign Policy – A Case Study of *Health is Global, A UK Government Strategy 2008-2013'* (2013) 9 Globalization and Health 24.

WHO, has been how best to accommodate the often competing demands of global health and international security.[28]

How to define global health security, as well as the merits or otherwise of securitizing health threats, have also been the subject of ongoing debate in the relevant academic and policy literatures. Key questions that need to be addressed in the quest for greater clarity include: Security for whom? Security for which values? How much security? Security from what threats? Security by what means? [29] At a policy level, a number of matters have been identified as coming within the remit of the global health security agenda. These include protection against threats; the emergence of new global conditions for which existing approaches are inadequate; the engagement of new actors including military establishments; and an explicit link to foreign policy interests in the development of health security policy. In practice, however, differing political and institutional imperatives and priorities have led to policy fragmentation in the area. This is in addition to problems with institutional communication and collaboration with key actors and interests on a number of important global health initiatives.[30]

Two particular problems have arisen in the context of defining the remit of the global health security agenda. First, the threat protection mentality inherent in the securitization approach clashes (and indeed may be largely incompatible) with the more optimistic and support-based approach taken to promoting primary healthcare, which has long been central to global health initiatives undertaken by international organizations, such as the WHO. Second, and related to the first point, if the expectation on the part of global political leaders is that states should be able to mount an effective response to health threats in line with a securitization approach, then it is difficult to see how this will result in an effective response,

[28] Sara E Davies, 'Securitizing Infectious Disease' (2008) 84(2) International Affairs 295; Adam Kamradt-Scott and Kelley Lee, 'The 2011 Pandemic Influenza Preparedness Framework: Global Health Secured Or A Missed Opportunity?' (2011) 59(4) Political Studies 831; David Heymann et al, 'Global Health Security: The Wider Lessons from the West African Ebola Virus Disease' (2015) 385(3880) The Lancet 1884.
[29] David A Baldwin, 'The Concept of Security' (1997) 23(1) Review of International Studies 5; Simon Rushton, 'Global Health Security: Security for Whom? Security from What?' (2011) 59(4) Political Studies 779.
[30] Aldis (n 8).

in the absence of addressing broader social determinants of health at the local level.[31] In short, the threat mentality inherent in the securitization approach appears ill-suited to addressing the often complex challenges that emerge and persist in managing health threats in the longer term. This is particularly problematic in the Global South, which bears most of the disease and mortality burden created by such threats, such as those posed by (pandemic) infectious diseases.[32] Having examined key aspects of the academic and policy debates in global health security, I now turn in the next section to explore the concept of medicalization and how it has been interpreted in the context of such debates.

Medicalization and global health security

The term medicalization has been used in various ways within the sociological and critical security studies literatures. In what has been described as the 'orthodox' approach within medical sociology,[33] the concept of medicalization has been employed to critique the social power and influence of the medical profession. In line with this critique, it was asserted that ever increasing areas of social life had become medicalized, notwithstanding the lack of evidence that many medical treatments were effective or enhanced the quality of life of patients. In addition, the desire for power and control on the part of the profession operated negatively to constrain patient autonomy and freedom.[34] In a challenge to key aspects of the orthodox critique, Michel Foucault argued that medical knowledge should be viewed as a disciplinary power that operated to guide patients in how they should understand and manage their bodies at the individual and population levels. As part of exercising such power, the medical profession was actively engaged in surveillance and control of human bodies in pursuit of social and political order. Conceptualized in this way, medicine was seen as collusive in its power relations across social groups, and with the state.[35] Although Foucault himself recognized that patients may resist the exercise of

[31] For an overview, see Michael Marmot, 'Social Determinants of Health Inequalities' (2005) 365(9464) The Lancet P1099.
[32] Harley Feldbaum and Kelley Lee, 'Public Health and Security' in Alan Ingram (ed), *Health, Foreign Policy and Security: Towards a Conceptual Framework for Research and Policy* (The Nuffield Trust 2004) 19; Davies (n 28); Gagnon and Labonté (n 27).
[33] See Lupton (n 11) 95.
[34] See for example, Eliot Freidson, *Professional Dominance: The Social Structure of Medical Care* (Aldine de Gruyter 1970); Ivan Illich, *Medical Nemesis: The Expropriation of Health* (Pantheon 1982).
[35] Michel Foucault, 'Truth and Power' in Paul Rabinow (ed), *The Foucault Reader* (Pantheon 1984) 51-75.

medical power to some extent,[36] scholars influenced by his writings have described patients as largely passive recipients of the exercise of such power.[37]

The way in which the term medicalization has been conceptualized in critical security studies scholarship draws on much of this earlier work, in order to describe doctors' engagement with the management of global health threats.[38] Medicalization is understood as a process whereby doctors seek to expand their power and influence in the context of managing health (in)security in the global political order.[39] Drawing on the Foucauldian perspective, medicine is viewed as a system of knowledge which is used to exercise power and control over human bodies in securitized environments.[40] In the circumstances, the work of doctors in such environments should not be seen as simply involving a set of technological procedures, or otherwise strongly influenced by the dynamics of interactions with patients. Instead, such work should be seen as intimately connected with power relations in the context of biopolitical governance.[41]

The process of medicalization in global health security is said to manifest itself in a number of ways in practice. First, it is observed through the growing number of medical professionals who have become involved in the development and implementation of security policy. This is evidenced in their involvement in foreign policy and security think tanks; their presence at high level security meetings; and their participation in global health security initiatives.[42] Second, doctors have become actively involved in managing insecurity, particularly in the context of emerging threats posed by the onset and spread of (pandemic) infectious diseases.[43] As part of continuous surveillance to secure populations, those with medical expertise are now involved in the development and stockpiling of pharmaceuticals,

[36] Michel Foucault, 'Body/Power' in Colin Gordon (ed), *Power/Knowledge: Selected Interviews and Other Writings, 1972-1977 Michel Foucault* (Pantheon 1980) 55-62.
[37] Lupton (n 11) 102.
[38] Elbe (n 11) 15-21.
[39] Peter Conrad, *The Medicalization of Society: On the Transformation of Human Conditions into Treatable Disorders* (John Hopkins University Press 2007) 4.
[40] Lupton (n 11).
[41] see Michel Foucault, 'The Birth of Social Medicine' in James D. Faubion (ed), *Power: Essential Works of Foucault, 1954-1984* (Penguin 2000) 134-56.
[42] Elbe (n 11) 25-26.
[43] Elbe (n 11) 22-23.

medical equipment and vaccines, otherwise described as 'medical countermeasures'.[44] Third, such surveillance requires that control is maintained over human bodies, now viewed as referent objects in the securitization of health threats. As one commentator has observed, they now constitute the new 'battlefield' in the twenty-first century, as security becomes 'somatic', in the sense that it functions through medical intervention in the human organism.[45] Adopting this perspective, human bodies are depicted as sites of potential and resistance, aspiration and threat, to be managed or otherwise reconfigured to align with security concerns.[46]

On one view, placing the role of those with medical expertise within a broader framework of biopolitical governance makes sense given the focus within the (critical) security studies literature on questions of high politics, such as state sovereignty, military capability and the imperatives of war and conflict. In adopting such a focus, however, what remains under-explored are the nuances, complexities and conundrums which structure the dynamics of the individual doctor-patient relationship in the context of managing health threats in securitized environments. Understanding such dynamics also requires that account be taken of how ethical and regulatory aspects of medical practice influence how doctors engage with securitization discourse and practice involving health threats to individual patients. Such aspects will necessarily shape the social context in which they engage in the therapeutic treatment of individual patients, as well as how they navigate risk assessment and management at the population level. In the following section, how such aspects impact upon the process of medicalization will be explored in more detail.

[44] Elbe et al. (n 2).
[45] Elbe (n 11) 165-68, drawing on the work of Nikolas Rose, *The Politics of Life Itself: Biomedicine, Power, and Subjectivity in the Twenty-First Century* (Princeton University Press 2007).
[46] Alison Howell, *Madness in International Relations: Psychology, Security and the Global Governance of Mental Health* (Routledge 2011); Stefan Elbe, 'Bodies as Battlefields: Toward the Medicalization of Insecurity' (2012) 6 International Political Sociology 320; Jessica Auchter, 'Paying Attention to Dead Bodies: The Future of Security Studies?' (2016) 1(1) Journal of Global Security Studies 36.

Role of ethics

The relationship between ethics and security is understood in largely abstract terms in critical security studies scholarship. An ethics of security is promoted as an idealized concept of progress or a universal good in the global political order. In questioning what role ethics might play in this context, academic commentators working in the field have explored moral norms in world politics; what concepts of progress or emancipation should be promoted in such circumstances; and what role should be played by human rights.[47] Focusing on these issues stems from a central concern with examining how and why the shift towards securitizing political problems occurs, and what consequences flow for states and the global governance as a result.[48] While the identification of moral norms, including those informed by human rights, is useful in understanding the ethical dimensions of securitization at the global level, it is somewhat limited in offering insights into the how the relationship between ethics and security impacts medical practice in addressing health threats.

In seeking to better understand the ethical obligations of doctors in securitized environments, insights may be gained from various (bio)ethical perspectives. The system of ethics known as principlism provides a useful starting point, given that it sets out a number of principles that should guide doctors in the treatment of patients under their care. They include respect for patient autonomy; beneficence (doing good); non-maleficence (doing no harm) and justice, which is used in this context to take account of the social distribution of burdens and benefits in the provision of healthcare.[49] 'Good medical practice' at the local level requires adherence to such principles in interactions with patients, such as obtaining consent for medical treatment, disclosing relevant medical information to patients regarding their health and maintaining medical confidentiality.[50] These and other ethical principles impacting

[47] Christopher S Browning, 'The Future of Critical Security Studies: Ethics and the Politics of Security' (2011) 19(2) European Journal of International Relations 235; Toni Erskine, 'Whose Progress, Which Morals: Constructivism, Normative IR Theory and the Limits and Possibilities of Studying Ethics in World Politics' (2012) 4(3) International Theory 449.
[48] Anthony Burke, Katrina Lee-Koo and Matt McDonald, 'An Ethics of Global Security' (2016) 1(1) Journal of Global Security Studies 64.
[49] For an overview of principlism, see Tom Beauchamp and James Childress, *Principles of Biomedical Ethics* (7th edn, Oxford University Press 2012).
[50] See for example in the UK context, General Medical Council, Ethical Guidance, <https://www.gmc-uk.org/ethical-guidance> accessed 3 May 2019.

doctor-patient relations have been incorporated into a range of international guidance. Examples include the Nuremberg Code which arose out of the war crimes committed by Nazi doctors in World War Two,[51] various Declarations promulgated by the World Medical Association (WMA) and UNESCO, as well as the Council of Europe's Convention on Human Rights and Biomedicine. Applying in the context of both clinical practice and medical research, they underline the overriding importance of upholding the dignity of the person and bodily integrity, which includes respect for patient autonomy and a prohibition on the commodification of, and/or trade in, the human body.[52]

The ethical obligations of doctors in times of war and armed conflict are also set out in international guidance, and reflects the fact that doctors take on diverse roles in such contexts. For example, while some may work as part of an established medical mission involved in caring for the wounded and sick, others may be engaged with caring for enemy combatants who are being subject to interrogation. Both scenarios give rise to ethical obligations on the part of doctors in relation to those under their care. Although international guidance contained in various WMA Declarations states that the same ethical principles apply to the conduct of medical practice in times of war or peace,[53] this may prove difficult to achieve in practice. Doctors may confront difficult ethical challenges in the face of competing political, military and security imperatives in war or armed conflict, combined with the fact that they must necessarily take account of a greater 'range of actors and interests' (i.e. combatants and non-combatants, enemies and allies, states and individuals, citizens and soldiers, prisoners of war, the wounded and the dying, those who can return to combat duty).'[54] Recent examples of ethically

[51] Evelyne Schuster, 'Fifty Years Later: The Significance of the Nuremberg Code' (1997) 337(20) NEJM 1436.
[52] See for example the Geneva Declaration (modern Hippocratic Oath), Declaration of Helsinki (medical research ethics), and the Declaration of Tokyo (prevention of torture by physicians). For a general overview of the history of WMA codes and guidance, see <https://www.wma.net/what-we-do/medical-ethics/> accessed 18 April 2019. Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine: Convention on Human Rights and Biomedicine (ETS No 164), 4 April 1997, Oviedo, Spain; Universal Declaration on Bioethics and Human Rights (UNESCO 2005) <https://unesdoc.unesco.org/ark:/48223/pf0000142825.page=80> accessed 24 April 2019.
[53] World Medical Association (WMA) Regulations in Times of Armed Conflict and Other Situations of Violence, General Guidelines (as at 15 February 2017) <www.wma.net/policies-post/wma-regulations-in-times-of-armed-conflict-and-other-situations-of-violence/> accessed 3 May 2019; see generally International Code of Medical Ethics of the WMA (as at 9 July 2018) <www.wma.net/policies-post/wma-international-code-of-medical-ethics/> accessed 3 May 2019.
[54] Michael L Gross, 'Bioethics and Armed Conflict: Mapping the Moral Dimensions of Medicine and War' (2004) 34(6) Hastings Center Report 22.

problematic behaviour on the part of doctors in these circumstances include those who condoned or colluded in degrading and inhumane treatment of prisoners and those under interrogation in the Abu Ghraib prison in Iraq,[55] as well as the active role played by doctors in the interrogation process involving individuals detained by the United States government at Guantanamo Bay.[56] Such examples highlight the difficulties some doctors face in drawing ethically (and indeed legally) acceptable lines in terms of the conduct of their work in securitized environments.

Doctors may also confront specific ethical conundrums in terms of how they engage with threats posed to both individuals and populations by (pandemic) infectious disease outbreaks, the management of which is seen as a key component of the global health security agenda. Current international guidance states that the conduct of doctors' work in such circumstances should be guided by key ethical principles such as justice, beneficence, respect for persons, utility, liberty, reciprocity and solidarity. These reflect principles that are considered important in the individual doctor-patient relationship and should also be seen as relevant to work undertaken in the context of managing such outbreaks at the population level, informing the design of policy and overall approach to managing global health threats in practice.[57] Key areas in which such principles would need to be applied in managing such threats include public health surveillance, the conduct of research, emergency use of unproven interventions, restrictions on freedom of movement, allocation of scarce resources, emergency use of unproven research, and the provision of medical treatment which takes account of gender-based differences and vulnerable populations. Current international ethical guidance stresses the importance of decision-making in such areas being based on a sound evidence base as to expected benefits and harms, in addition to reasoning by analogy where this is not possible.[58]

[55] Steven H Miles, 'Abu Ghraib: Its Legacy for Military Medicine' (2004) 364(9435) The Lancet P725.
[56] M Gregg Bloche and Jonathan H Marks, 'Doctors and Interrogators at Guantanamo Bay' (2005) 353(1) New England Journal of Medicine 6, 8.
[57] World Health Organization, *Guidance for Managing Ethical Issues in Disease Outbreaks* (World Health Organization 2016) 8-9.
[58] Ibid 9.

Role of regulation

Regulation is also vital in determining what is (and conversely what is not) considered ethically acceptable by doctors in the conduct of their medical practice. In this regard, the coercive aspects of regulation have long been considered useful in facilitating an ethically principled approach to medical practice.[59] So how should we understand the role of regulation in global health security? For critical security scholars, regulation has largely been described in functional terms, to be employed for the purposes of standard-setting or prohibition in the service of a broader health security agenda.[60] For legal scholars, however, there has been much debate about the role, function and future(s) of law and regulation in global health. Traditionally, law has been described as inadequate in dealing with the phenomenon of globalization and its consequences, as well as in dealing with increasing health inequalities. International law is said to offer only vague standards, weak enforcement and an approach that favours states' views over collective public health.

Although there has been a tendency to focus more on the more formal role of law in global health (e.g. legislation, treaties, legal institutions),[61] the reality is that beyond the nation-state there is often a mix of (legally binding) rules and (non-legally binding) guidance which may both need to align to promote effective political action and political support to address a pressing global health problem, such as an outbreak of pandemic infectious disease.[62] In the circumstances, it is perhaps best to describe the role of law as forming part of a broader approach to regulatory governance in global health security. In doing so, it is helpful to draw on insights from the regulatory studies literature, which recognizes the importance of understanding regulation as part of multi-level governance that is context-driven and contingent. In terms of context, there is a recognition of the need to take account of social understandings, political,

[59] Jonathan Montgomery, 'Time for a Paradigm Shift: Medical Law in Transition' (2000) 53(1) Current Legal Problems 363.
[60] Elbe et al (n 2); Enemark (n 2).
[61] Fidler and Gostin (n 2).
[62] Allyn L Taylor et al, 'Leveraging Non-Binding Instruments for Global Health Governance: Reflections From The Global AIDS Reporting Mechanism For WHO Reform' (2014) 128 Global Health 151; Nayha Sethi, 'Research and Global Health Emergencies: On the Essential Role of Best Practice' (2018) 11(3) Public Health Ethics 237.

institutional and market processes which impact behaviour, institutions and governance arrangements.[63] Regulation may also be seen as contingent due to fragmentation, complexity and heterarchy at the global level, with incentivization to abide by such instruments being facilitated not solely as a result of formal legal competence but rather through networks comprised of experts, regulators, non-government organizations, interest groups and representatives from local, regional and international organizations.[64] Conceptualized in this way, law – in the form of legally-binding instruments and institutions – should be seen as one method among several in regulatory governance of global health security for incentivizing ethically acceptable medical practice in securitized environments.

Beyond the nation-state, the symbiotic relationship between medical ethics and regulation can be observed across a number of legal regimes.[65] Examples include the translation of key aspects of international medical ethics guidance into mandatory norms under international humanitarian law (IHL), which applies in the case of both intra- and inter-state conflict. Under IHL, emphasis is placed on the overriding importance of doctors' upholding ethical obligations in medical practice in relation to the care of the wounded and sick. Such obligations are expected to be adhered to even in the face of undue pressure being exerted upon doctors by military or security forces to participate in degrading or inhuman treatment or torture of individuals who are wounded or sick, or otherwise deprived of liberty under their care.[66] For doctors to act in contravention of such norms in circumstances where the wounded or sick under their care are placed in physical or mental danger, or where there is a deliberate refusal to provide necessary medical treatment, would be considered a war crime under IHL.[67]

[63] Peter Drahos (ed), *Regulatory Theory: Foundations and Applications* (ANU Press 2017).
[64] Julia Black, 'Constructing and Contesting Legitimacy and Accountability in Polycentric Regulatory Regimes' (2008) 2(2) Regulation & Governance 137; Peter Drahos, 'Regulatory Globalisation' in Drahos (n 63) 249-62.
[65] The relationship between medical ethics and law has been described as symbiotic in the sense that they are often mentioned together and interact with each other in the context of talking about medical practice, see José Miola, *Medical Ethics and Medical Law: A Symbiotic Relationship* (Hart 2007).
[66] Geneva Conventions, API, Art. 16.1; APII, Art. 10.1.
[67] Geneva Conventions, GCI Art. 50; GCII Art 51; GCIII Art. 130, GCIV Art. 147; API Art. 11. For a detailed overview, see Médecins Sans Frontières, The Practical Guide to International Humanitarian Law – Medical Ethics <https://guide-humanitarian-law.org/content/article/3/medical-ethics/> accessed 23 April 2019.

Another example is provided by international human rights law which has become increasingly important in recent decades in determining what is considered morally and legally acceptable on the part of states in the case of health threats, such as those posed by pandemic infectious diseases. As noted earlier in the chapter, this is exemplified in the IHR, which states that PHEICs must now be managed with 'full respect for the dignity, human rights and fundamental freedoms of persons'.[68] In line with such an approach, states are now required to identify a public health risk that justifies imposing health measures against persons, in addition to applying an appropriate health response to such risk. Implementation of measures must be no more intrusive of persons than reasonably available alternatives that would achieve the level of health protection required. However, what is not made clear in the IHR is the extent to which this balancing exercise should take account of the relationship between health security and human rights.[69]

There is also a lack of clarity with regards to the role bioethical principles should play in facilitating good medical practice in managing such risks in securitized environments. Indeed, it has long been recognized that a close relationship exists between (bio)ethical principles and human rights in terms of norms development at the global level.[70] This is exemplified in a range of international legal instruments which echo ethical guidance regarding prohibitions on torture or cruel, inhuman or degrading treatment or punishment and from medical or scientific experimentation.[71] In addition, it is also made clear that there is only a very limited range of circumstances in which derogations from (parts of) such instruments are possible in times of public emergency.[72] Excluded from such derogations are the right to life, as well as

[68] IHR, Art 3.1.
[69] Joseph J Amon, 'Health Security and/or Human Rights?' in Simon Rushton and Jeremy Youde (eds), *Routledge Handbook on Global Health Security* (Routledge 2015) 293-303.
[70] As to the relationship between bioethics and international human rights law, see Richard Ashcroft, 'Could Human Rights Supersede Bioethics?' (2010) 10(4) Human Rights Law Review 639, drawing on Thomas Faunce, ''Will International Human Rights Subsume Medical Ethics? Intersections in the UNESCO Universal Bioethics Declaration' (2004) 31 Journal of Medical Ethics 173.
[71] UN General Assembly, Universal Declaration on Human Rights, 217 A (III), Art 5; UN General Assembly, Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, United Nations, Treaty Series, Vol. 1465, p. 85.
[72] UN General Assembly, International Covenant on Civil and Political Rights, 16 December 1966, United Nations, Treaty Series, vol. 999, p. 171, Art 4; Siracusa Principles on the Limitation and Derogation of Provisions in the International Covenant on Civil and Political Rights Annex, UN Doc E/CN.4/1984/4 (1984).

freedom from torture or cruel, inhuman or degrading treatment or punishment and from medical or scientific experimentation.[73]

Further guidance on the issue can be gleaned from what are known as the Siracusa Principles, which establish a framework for assessing the extent to which restrictions of fundamental human rights are permissible under law and which could also be said to be in the public interest. Broadly speaking, public health measures which seek to restrict civil and political rights can only be justified on the basis that they are responding to a pressing public or social need and where they are considered strictly necessary and proportionate to pursuing a legitimate aim. There should also be scientific evidence available which clearly supports such a course of action. Where any individuals are deprived of their liberty, they must be treated with humanity and respect for the inherent dignity of the human person. Where restrictions are justified on any of the above grounds, they must not be undertaken in an arbitrary, unreasonable or discriminatory manner.[74] While international human rights law could be said to offer a welcome check on ethically problematic medical practice in securitized environments, concerns remain about how this would actually work in practice to protect individual patients and vulnerable populations in the management of health threats at the local level.[75]

Conclusion

This chapter examined the concept of medicalization in the global health security literature. For critical security studies scholars working in the field, it is viewed in largely Foucauldian terms as a process which facilitates the social influence and power of medicine as a system of knowledge for surveillance and control of human bodies at the individual and population levels. Positioning the role and function of medical expertise in this way aligns with much of the focus scholars working in the field on higher level questions of state sovereignty, military capability and security imperatives in managing health threats. Yet what is under-explored in such literature is how the dynamics of doctor-patient relations

[73] Siracusa Principles (n 72) Art 69(a)(b).
[74] Ibid, Principles 1-14.
[75] Lawrence O Gostin and James G Hodge, 'Global Health Law, Ethics, and Policy' (2007) 35(4) Journal of Law Medicine and Ethics 519, 522.

impact medical practice in managing health threats in securitized environments. Such examination revealed that ethical obligations have a particularly important role to play in medical practice in such environments, to be applied not only in the case of individual patients but also in doctors' assessment and management of risks posed by health threats at the population level. They are obligations that are embedded in both national and international ethical guidance, as well as being underpinned by regulation which involves both legally-binding and non-binding instruments. Such instruments are designed to incentivize doctors to engage in ethically acceptable medical practice in securitized environments.

What this examination also highlighted was the fact that the logic of medicine sits uneasily at times with the logic of securitization. While a range of national and international guidance emphasizes the primacy of upholding ethical obligations, the reality of medical practice in securitized environments is that doctors are likely to be confronted with a range of competing ethical, military and political imperatives in the performance of their work. While such logics may coalesce in some respects, they also differ quite dramatically in others. What is particularly troubling is that where well-established ethical obligations which are central to doctor-patient relations conflict with security imperatives, available evidence points to some doctors having favoured the latter in their medical practice. In the circumstances, we need to be circumspect in lauding the shift towards securitizing health threats at the global level. A securitization approach offers a fairly narrow view of what needs to be prioritized in policy terms and it clearly has the potential to facilitate ethically problematic behaviour on the part of doctors in certain circumstances, examples of which were provided in the chapter.

As currently conceptualized within the critical security studies literature, medicalization does little to assist with understanding the competing logics of medicine and security. Drawing on insights from medical law, bioethics and regulatory studies literatures, I have identified the problems that can arise in the context of such competing logics, focusing on the complex interplay of ethical and regulatory obligations that shape the process of medicalization at both the individual and population levels. Future research in the area would benefit from drawing on socio-legal insights into patient-doctor relations, as

well as empirical analysis of how medicalization translates into practice in different securitized environments. In policy terms, it remains important that local and global institutions, as well as expert networks, continue to emphasise the overriding importance of adherence to ethically acceptable medical practice in securitized environments. This should be incentivized through the use of regulatory instruments where possible, so as to facilitate transparency and accountability on the part of doctors in global health security and practice.